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Preface

Health Reports is a list of reports and testimonies issued by the General Accounting Office (GAO) over the past 2 years. Organized chronologically, the entries provide a title, report number, and issue date for each GAO health product. Reports and testimonies on the same topic may be combined into a single entry.

The first section—Recent GAO Products—summarizes reports and testimonies on selected health issues published from May through August 1992. The summaries are followed by a list of additional products published during the same period. The remainder of Health Reports is a list of health products published from September 1990 through August 1992 organized by subject areas as shown in the table of contents. As appropriate, entries have been cross-indexed and are included in more than one subject area. An order form to be placed on our mailing list for Health Reports is on page 37 of this report. An order form to request GAO products is on page 38.

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Abbreviations

ADMS	Alcohol, Drug Abuse and Mental Health Services
ADP	automatic data processing
AIDS	acquired immunodeficiency syndrome
CDC	Centers for Disease Control
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CPI	Consumer Price Index
DOD	Department of Defense
ERISA	Employee Retirement Income Security Act of 1974
FDA	Food and Drug Administration
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
MRI	Magnetic Resonance Imaging
NAIC	National Association of Insurance Commissioners
OSHA	Occupational Safety and Health Administration
PRO	peer review organization
VA	Department of Veterans Affairs
WIC	Special Supplemental Food Program for Women, Infants, and Children

Recent GAO Products (May-Aug. 1992)

Summaries of Selected Reports

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (Aug. 26, 1992, GAO/HRD-92-76).

The case study of the rolling labs scheme illustrates the vulnerability of Medicare and other health insurers to health care fraud. Investigators believe that this scheme, initially rooted in the Medicare program, is the largest case of health care fraud ever identified. Since the early 1980s, the scheme grew to involve hundreds of physicians and numerous medical laboratories and an estimated $1 billion in fraudulent claims to public and private insurers. The report highlights some of the lessons learned by health insurers in their efforts to address fraud.

Prescription Drugs: Changes in Prices for Selected Drugs (Aug. 24, 1992, GAO/HRD-92-128).

GAO examined recent price increases for 29 widely used drug products purchased by pharmacies and the Department of Veterans Affairs (VA). From 1985 to 1991, prices for nearly all of the products increased more than the three consumer price indexes. During this period, the maximum price increase for each product generally exceeded 100 percent, with some prices increasing more than 200 percent. During this same period, the all item Consumer Price Index (CPI) increased by 26.2 percent, the medical care CPI increased by 56.3 percent, and the prescription drug CPI increased by 67 percent.

Women's Health Information: HHS Lacks an Overall Strategy (Aug. 5, 1992, GAO/T-HRD-92-51).

GAO's ongoing work indicates that the Department of Health and Human Services (HHS), which is responsible for providing health information to the public, lacks an overall strategy for getting health information to women. Even when information for the public is produced and distributed, it is not always easily accessible. HHS does not routinely evaluate the usefulness of information provided.

Medicaid Prescription Drug Diversion: A Major Problem, But State Approaches Offer Some Promise (July 29, 1992, GAO/T-HRD-92-48).

The fraudulent reselling of prescription drugs is a prevalent type of Medicaid fraud that state Medicaid agencies are beginning to address more actively. A common fraud scheme involves "pill mills"—that is, a doctor's office, clinic, or pharmacy whose principal business is the illegal diversion

of prescription drugs. Officials in 21 states cite such drug diversion as a major problem. Pill mills remain particularly resistant to enforcement efforts. Recent state initiatives offer considerable potential for overcoming stumbling blocks, curbing diversion, and recovering financial losses.

Health Insurance: More Resources Needed to Combat Fraud and Abuse (July 28, 1992, GAO/T-HRD-92-49). Report on same topic (May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

The size of the health care sector and sheer volume of money involved make it an attractive target for fraud and abuse. Profiteers are able to stay ahead of those who pay claims, in part, because of the obstacles to preventing and pursuing dishonest practices. Once detected, fraud is expensive and slow to pursue. The two federal agencies significantly involved in pursuing health care fraud cite resources as a problem. Because of the complexity involved in overcoming structural issues, GAO asked the Congress to consider establishing a national commission to develop comprehensive solutions to health insurance fraud and abuse.

Prescription Drug Monitoring: States Can Readily Identify Illegal Sales and Use of Controlled Substances (July 21, 1992, GAO/HRD-92-115).

Prescription drug monitoring programs save investigators' time and improve their productivity by providing information that allows them to identify potential cases of drug diversion. Prescription drug monitoring programs were not designed to measure their effect on reducing health care costs; however, 2 of the 10 states have reduced state Medicaid prescription drug costs by an estimated $27 million over 2 years and $440,000 for 1 year. Claims by medical, pharmaceutical, and patient organizations that prescription drug monitoring programs adversely affect a physician's ability to practice medicine or compromise patient care or confidentiality have not been sustained.

Medicare: Program and Beneficiary Costs Under Durable Medical Equipment Fee Schedules (July 7, 1992, GAO/HRD-92-78).

The durable medical equipment fee schedules established under the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) resulted in both Medicare and its beneficiaries paying more than they would have under the former system. For the high-volume items we reviewed, 1989 Medicare costs increased 17 percent. When revisions in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) are fully implemented, Medicare

payments will return to the same level that would have been incurred under the former system.

VA Health Care for Women: Despite Progress, Improvements Needed (July 2, 1992, GAO/T-HRD-92-33). Testimony on same topic (June 19, 1992, GAO/T-HRD-92-42). Report on same topic (Jan. 23, 1992, GAO/HRD-92-23).

VA has made significant progress since 1982 toward ensuring that female veterans have equal access to health care as male veterans. However, some problems remain in caring for women veterans. Physical examinations, including cancer screening, continue to be sporadic. VA medical centers are inadequately monitoring in-house mammography programs to ensure compliance with American College of Radiology quality standards.

Medicaid: Factors to Consider in Managed Care Programs (June 29, 1992, GAO/T-HRD-92-43).

Medicaid is being severely strained by the continuing rise in the size of its population and cost. At the same time, there is general unhappiness with the traditional fee-for-service Medicaid program. Federal and state policy makers are turning to managed care as a possible way of getting better access and quality for the money they spend. GAO's previous reviews of Medicaid managed care programs have identified problems with access to care, quality of services, and oversight of provider financial reporting, disclosure, and solvency. Results from GAO's current review in Oregon, however, indicate that concerns about these problems can be lessened through improved oversight and appropriate safeguards.

Elderly Americans: Health, Housing, and Nutrition Gaps Between the Poor and Nonpoor (June 24, 1992, GAO/PEMD-92-29). Testimony on same topic (June 24, 1992, GAO/T-PEMD-92-10).

Although nearly all elderly persons had health insurance coverage through Medicare, poor elderly persons (1) were less likely to have private health insurance coverage to supplement Medicare, (2) spent a much higher percentage of their income on out-of-pocket health care expenses for noninstitutional care, and (3) were more likely to suffer from acute and chronic conditions than were nonpoor elderly persons. Moreover, only about 1 in 3 poor elderly persons were enrolled in Medicaid—the nation's health insurance program for the poor.

Long-Term Care Insurance: Actions Needed to Reduce Risks to Consumers (June 23, 1992, GAO/T-HRD-92-44).

GAO and others have identified significant problems with long-term care insurance policies and the standards that govern them. GAO has also identified problems with insurance companies selling long-term care insurance to low-income people. The National Association of Insurance Commissioners (NAIC) has developed model standards for long-term care insurance. Consumers, however, are still vulnerable to considerable risks because (1) many states and insurance companies have not adopted all the NAIC standards, (2) NAIC standards do not sufficiently address several features of long-term care insurance that have important consequences for consumers, and (3) low-income people who purchased this expensive insurance may be covered by a government program such as Medicaid.

Medicaid: Oregon's Managed Care Program and Implications for Expansions (June 19, 1992, GAO/HRD-92-89).

Oregon's Medicaid managed care program has avoided many of the problems identified in other states. The current program, while generally sound, could be improved by (1) insuring that efforts to improve child health screening services receive high priority, (2) revising its client satisfaction surveys, (3) intensifying its oversight of health plan solvency, and (4) requiring better financial information from the plans. Regarding the proposed demonstration, GAO is concerned that Oregon may not be able to recruit enough managed care providers within the first year to ensure access to health services for the quickly expanding managed care population.

Medicaid: Ensuring That Noncustodial Parents Provide Health Insurance Can Save Costs (June 17, 1992, GAO/HRD-92-80).

States are not ensuring that noncustodial parents provide health insurance for their children, even when such insurance is available through the noncustodial parents' employers. GAO estimates that the states and the federal government can save at least $122 million in medical expenditures annually if noncustodial parents provide health insurance that is available through their employment. Two main problems limit the effectiveness of state enforcement efforts: (1) federal laws permit wide variability in state laws and practices used to enforce medical support, and (2) self-insuring employers with health plans covered by the Employee Retirement Income

Security Act of 1974 (ERISA) can exclude noncustodial parents' children from coverage.

Access to Health Care: States Respond to Growing Crisis (June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

States have taken a leadership role in devising strategies to expand access to health insurance and contain the growth of health costs. A difficult hurdle to overcome, however, is the restrictions imposed by the preemption clause of ERISA. This clause effectively prevents states from exercising control over all employer-provided insurance. Hawaii is the only state with an exemption, in part because its law requiring employer-provided health insurance took effect before ERISA was enacted. Other states have tried to move toward coverage of all their citizens within ERISA's constraints. Some state initiatives have been more narrowly focused, creating programs to assist specific groups. State budgetary constraints, however, have limited these programs to serving a small fraction of the uninsured population.

Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments (June 12, 1992, GAO/HRD-92-64).

The Health Care Financing Administration (HCFA) could reduce Medicare expenditures on certain durable medical equipment by developing more detailed coverage criteria that give carriers a clear, well-defined, objective basis for paying or denying claims. To save additional Medicare funds, HCFA could also develop medical necessity certification forms for equipment subject to unnecessary payments.

Screening Mammography: Federal Quality Standards Are Needed (June 5, 1992, GAO/T-HRD-92-30).

GAO reported in Screening Mammography: Low-Cost Services Do Not Compromise Quality (Jan. 10, 1990, GAO/HRD-90-32) that many screening mammography providers surveyed lacked the quality assurance programs needed to ensure safe and accurate mammograms for women. GAO also identified a need for strong federal standards to assure quality of screening mammography. The Congress required the Secretary of HHS to establish quality standards for mammography providers serving the Medicare population. Of significant concern, however, are the 30 million women not eligible for Medicare who should obtain regular screening and are not necessarily protected by federal quality standards.

VA Health Care: The Quality of Care Provided by Some VA Psychiatric Hospitals Is Inadequate (June 3, 1992, GAO/T-HRD-92-37). Report on same topic (Apr. 22, 1992, GAO/HRD-92-17).

In fiscal year 1990, VA spent approximately $1.3 billion to operate and maintain its mental health care programs and facilities. None of the four VA psychiatric hospitals GAO visited are effectively collecting and using quality assurance data on a consistent basis to identify and resolve quality-of-care problems. GAO recommends that the Secretary of Veterans Affairs require the Chief Medical Director to: (1) define treatment goals, provide guidance on the evaluation of these goals, and ensure program reviews to evaluate the attainment of the goals; and (2) hold each hospital director responsible for making certain that identified medical and psychiatric quality-of-care problems are thoroughly examined and corrective actions are taken.

Childhood Immunization: Opportunities to Improve Immunization Rates at Lower Cost (June 1, 1992, GAO/T-HRD-92-36).

Childhood immunization is one of the most effective means of health promotion and disease prevention. It could avert the costs of treatment for preventable diseases and save as much as $14 for every $1 invested. Yet GAO found that the average preschool full immunization rate among the states was 59 percent in 1990. According to the Centers for Disease Control (CDC), only about one-third of all urban preschool children are fully immunized. States told GAO that funding for purchasing and distributing CDC contract vaccines is a major barrier. Furthermore, implementing a system to handle, store, and distribute vaccines requires additional spending and also expands the states' traditional public health role.

Federally Funded Health Services: Information on Seven Programs Serving Low-Income Women and Children (May 28, 1992, GAO/HRD-92-73FS).

This fact sheet provides information on services, eligibility, and program interrelationships for seven programs that fund the delivery of health services to low-income women and children. The programs are the Preventive Health and Health Services block grant; Maternal and Child Health block grant; Early and Periodic Screening, Diagnosis, and Treatment portion of Medicaid; Childhood Immunization Program; Childhood Lead Poisoning Prevention; Community Health Centers; and Migrant Health Centers. GAO found that requirements for inter-program coordination were not well defined.

Medicare: Excessive Payments Support the Proliferation of Costly Technology (May 27, 1992, GAO/HRD-92-59).

In some localities, Medicare's technical component payments for Magnetic Resonance Imaging (MRI) do not reflect the lower costs per scan now being achieved through faster scanning and higher machine utilization. Current payment levels are based, in part, on the charges allowed by local Medicare contractors in the mid-1980s. The 1991 payment levels in some localities were more than twice as high as in others, reflecting wide geographic disparities in the historical allowed charges. Medicare should base its payments on the costs incurred by high-volume, efficient facilities to reduce Medicare program expenditures and to discourage providers from adding excess capacity to the health care system.

Contractor Oversight and Funding Need Improvement (May 21, 1992, GAO/T-HRD-92-32).

GAO's work in recent years suggests that HCFA may need to exercise more active oversight over its contractors. Investigations into allegations of fraud and abuse and recovery of mistaken payments have not been adequate. Funding for Medicare's program safeguards has not kept pace with the growth in claims volume. GAO believes that HCFA must take a more active stance to hold contractors accountable for their performance in program administration.

Long-Term Care Insurance: Better Controls Needed to Protect Consumers (May 20, 1992, GAO/T-HRD-92-31).

GAO found that despite NAIC standards, consumers are still vulnerable to considerable risks in purchasing long-term care insurance. Consumers are at risk because many states have not adopted key NAIC standards. Also the NAIC standards themselves do not sufficiently address several features of long-term care insurance, such as policy terminology, definitions, and eligibility criteria. GAO believes that additional standards are necessary to (1) promote uniform terminology and definitions, (2) establish guidelines that address the relevance of eligibility criteria to different types of impairments, and (3) establish formal grievance procedures.

Access to Health Insurance: State Efforts to Assist Small Businesses (May 14, 1992, GAO/HRD-92-90). Testimony on same topic (May 14, 1992, GAO/T-HRD-92-30).

GAO found that most states have proposed or already implemented programs to try to expand small business employees' access to health insurance coverage. Many of these initiatives have been adopted within the past 2 years, but the early indications are that they have led to only modest gains in the number of firms offering health insurance. This is largely because costs have not been reduced sufficiently to induce small firms to offer health insurance.

List of Additional GAO Health Products

Operation Desert Storm: Full Army Medical Capability Not Achieved (Aug. 18, 1992, GAO/NSIAD-92-175).

VA Health Care: Offsetting Long-Term Care Costs by Adopting State Copayment Practices (Aug. 12, 1992, GAO/HRD-92-96).

VA Health Care: Demonstration Project Concerning Future Structure of Veterans' Health Program (Aug. 11, 1992, GAO/T-HRD-92-53).

Recombinant Bovine Growth Hormone: FDA Approval Should be Withheld Until the Mastitis Issue Is Resolved (Aug. 6, 1992, GAO/PEMD-92-26).

VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (Aug. 5, 1992, GAO/T-HRD-92-50). Report on same topic (July 29, 1992, GAO/HRD-92-114).

VA Health Care: Role of the Chief of Nursing Service Should Be Elevated (Aug. 4, 1992, GAO/HRD-92-74).

Elderly Americans: Nutrition Information Is Limited and Guidelines Are Lacking (July 30, 1992, GAO/T-PEMD-92-11).

Employee Benefits: Financing Health Benefits of Coal Industry Retirees (July 22, 1992, GAO/HRD-92-137FS).

Employee Benefits: Financing Health Benefits of Retired Coal Miners (July 22, 1992, GAO/HRD-92-130FS).

Medicare: Reimbursement Policies Can Influence the Setting and Cost of Chemotherapy (July 17, 1992, GAO/PEMD-92-28).

Health Care: Most Community and Migrant Health Center Physicians Have Hospital Privileges (July 16, 1992, GAO/HRD-92-98).

Public/Private Elder Care Partnerships: Balancing Benefit and Risk (July 9, 1992, GAO/T-HRD-92-45). Report on same topic (July 7, 1992, GAO/HRD-92-94).

Federal Health Benefits Program: Open Season Processing Timeliness (July 8, 1992, GAO/GGD-92-122BR).

Practitioner Data Bank: Information on Small Medical Malpractice Payments (July 7, 1992, GAO/IMTEC-92-56).

VA Health Care: Alternative Health Insurance Reduces Demand for VA Health Care (June 30, 1992, GAO/HRD-92-79).

VA Health Care: Copayment Exemption Procedures Should Be Improved (June 24, 1992, GAO/HRD-92-77).

Foreign Assistance: Combating HIV/AIDS in Developing Countries (June 19, 1992, GAO/NSIAD-92-244).

Administration on Aging: Operations Have Been Strengthened but Weaknesses Remain (June 11, 1992, GAO/PEMD-92-27). Testimony on same topic (June 11, 1992, GAO/T-PEMD-92-9).

VA Health Care: Delays in Awarding Major Construction Contracts (June 11, 1992, GAO/HRD-92-111).

VA Health Care: Efforts to Improve Pharmacies' Controls Over Addictive Drugs (June 10, 1992, GAO/T-HRD-92-38).

Employee Drug Testing: Estimated Cost to Test All Executive Branch Employees and New Hires (June 10, 1992, GAO/GGD-92-99).

Health Care: VA's Implementation of the Nurse Pay Act of 1990 (June 3, 1992, GAO/T-HRD-92-35).

Medical ADP Systems: Composite Health Care System Is Not Ready to Be Deployed (May 20, 1992, GAO/IMTEC-92-54).

Financial Reporting: Accounting for the Postal Service's Postretirement Health Care Costs (May 20, 1992, GAO/AFMD-92-32).

Occupational Safety & Health: Worksite Safety and Health Programs Show Promise (May 19, 1992, GAO/HRD-92-68). Testimony on same topic (Feb. 26, 1992, GAO/T-HRD-92-15).

Occupational Safety & Health: Options to Improve Hazard-Abatement Procedures in the Workplace (May 12, 1992, GAO/HRD-92-105).

Occupational Safety & Health: Employers' Experiences in Complying With the Hazard Communication Standard (May 8, 1992, GAO/HRD-92-63BR).

Pharmaceutical Industry: Tax Benefits of Operating in Puerto Rico (May 4, 1992, GAO/GGD-92-72BR).

University Research: Controlling Inappropriate Access to Federally Funded Research Results (May 4, 1992, GAO/RCED-92-104).

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Health Insurance: More Resources Needed to Combat Fraud and Abuse (July 28, 1992, GAO/T-HRD-92-49). Report on same topic (May 7, 1992, GAO/HRD-92-69). Testimony on same topic (May 7, 1992, GAO/T-HRD-92-29).

Access to Health Care: States Respond to Growing Crisis (June 16, 1992, GAO/HRD-92-70). Testimony on same topic (June 9, 1992, GAO/T-HRD-92-40).

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Access to Health Insurance: States Attempt to Correct Problems in Small Business Health Insurance Market (May 14, 1992, GAO/HRD-92-90). Testimony on same topic (May 14, 1992, GAO/T-HRD-92-30).

Early Intervention: Federal Investments Like WIC Can Produce Savings (Apr. 7, 1992, GAO/HRD-92-18).

Maternal and Child Health: Block Grant Funds Should be Distributed More Equitably (Apr. 2, 1992, GAO/HRD-92-5).

Health Care: Problems and Potential Lessons for Reform (Mar. 27, 1992, GAO/T-HRD-92-23).

Small Group Market Reforms: Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (Mar. 12, 1992, GAO/HRD-92-27R).

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (Feb. 28, 1992, GAO/HRD-92-54).

Health Care Spending: Nonpolicy Factors Account for Most State Differences (Feb. 13, 1992, GAO/HRD-92-36).

Federal Health Benefits Program: Stronger Controls Needed to Reduce Administrative Costs (Feb. 12, 1992, GAO/GGD-92-27).

Budget Issues: 1991 Budget Estimates: What Went Wrong (Jan. 15, 1992, GAO/OCG-92-1).

Hispanic Access to Health Care: Significant Gaps Exist (Jan. 15, 1992, GAO/PEMD-92-6). Testimony on same topic (Sept. 19, 1991, GAO/T-PEMD-91-13).

Health Care Spending Control: The Experience of France, Germany, and Japan (Nov. 15, 1991, GAO/HRD-92-9). French and German translations available (Nov. 15, 1991, GAO/HRD-92-9ES). Testimony on same topic (Nov. 19, 1991, GAO/T-HRD-92-12).

Off-Label Drugs: Reimbursement Policies Constrain Physicians in Their Choice of Cancer Therapies (Sept. 27, 1991, GAO/PEMD-91-14).

States Need More Department of Labor Help to Regulate Multiple Employer Welfare Arrangements and Correct Problems (Sept. 17, 1991, GAO/T-HRD-91-47).

Managed Care: Oregon Program Appears Successful But Expansion Should Be Implemented Cautiously (Sept. 16, 1991, GAO/T-HRD-91-48).

Rural Hospitals: Closures and Issues of Access (Sept. 4, 1991, GAO/T-HRD-91-46).

Nonprofit Hospitals: Better Standards Needed for Tax Exemption (July 10, 1991, GAO/T-HRD-91-43). Report on same topic (May 30, 1990, GAO/HRD-90-84).

Private Health Insurance: Problems Caused by a Segmented Market (July 2, 1991, GAO/HRD-91-114). Testimony on same topic (May 2, 1991, GAO/T-HRD-91-21).

U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (June 10, 1991, GAO/HRD-91-102). French and German translations available (June 10, 1991, GAO/HRD-91-102). Testimony on same topic (Apr. 17, 1991, GAO/T-HRD-91-16).

Canadian Health Insurance: Lessons for the United States (June 4, 1991, GAO/HRD-91-90). Testimony on same topic (June 4, 1991, GAO/T-HRD-91-35).

Trauma Care: Lifesaving System Threatened by Unreimbursed Costs and Other Factors (May 17, 1991, GAO/HRD-91-57).

Retiree Health: Company-Sponsored Plans Facing Increased Costs and Liabilities (May 6, 1991, GAO/T-HRD-91-25).

Workers at Risk: Increased Numbers in Contingent Employment Lack Insurance, Other Benefits (Mar. 8, 1991, GAO/HRD-91-56).

Medigap Insurance: Better Consumer Protection Should Result From 1990 Changes to Baucus Amendment (Mar. 5, 1991, GAO/HRD-91-49).

Rural Hospitals: Federal Efforts Should Target Areas Where Closures Would Threaten Access to Care (Feb. 15, 1991, GAO/HRD-91-41).

Health Insurance Coverage: A Profile of the Uninsured in Selected States (Feb. 8, 1991, GAO/HRD-91-31FS).

Home Visiting: A Promising Early Intervention Service Delivery Strategy (Oct. 2, 1990, GAO/T-HRD-91-02). Report on same topic (July 11, 1990, GAO/HRD-90-83).

Medicare and Medicaid

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Contractor Oversight and Funding Need Improvement (May 21, 1992, GAO/T-HRD-92-32).

Medicaid: Factors to Consider in Expanding Managed Care Programs (Apr. 10, 1992, GAO/T-HRD-92-26).

Medicare: Shared Systems Policy Inadequately Planned and Implemented (Mar. 18, 1992, GAO/IMTEC-92-41). Testimony on same topic (Mar. 18, 1992, GAO/T-IMTEC-92-11).

Medicare: Payments for Medically Directed Anesthesia Services Should Be Reduced (Mar. 3, 1992, GAO/HRD-92-25).

Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (Feb. 21, 1992, GAO/HRD-92-52).

Medicare: Rationale for Higher Payment for Hospital-Based Home Health Agencies (Jan. 31, 1992, GAO/HRD-92-24).

Medicare: Third Status Report on Medicare Insured Group Demonstration Projects (Jan. 29, 1992, GAO/HRD-92-53).

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (Nov. 15, 1991, GAO/T-HRD-92-11). Report on same topic (Nov. 12, 1991, GAO/HRD-92-11).

Medicare: Effect of Durable Medical Equipment Fee Schedules on Six Suppliers' Profits (Nov. 6, 1991, GAO/HRD-92-22).

Significant Reductions in Corporate Retiree Health Liabilities Projected If Medicare Eligibility Age Lowered to 60 (Nov. 5, 1991, GAO/T-HRD-92-7).

Medicare: Millions of Dollars in Mistaken Payments Not Recovered (Oct. 21, 1991, GAO/HRD-92-26).

Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (Oct. 2, 1991, GAO/HRD-92-1). Testimony on same topic (Oct. 2, 1991, GAO/T-HRD-92-2).

Medicaid: Changes in Drug Prices Paid by VA and DOD Since Enactment of Rebate Provisions (Sept. 18, 1991, GAO/HRD-91-139).

Health Care: Actions to Terminate Problem Hospitals From Medicare Are Inadequate (Sept. 5, 1991, GAO/HRD-91-54).

Medicare: Information Needed to Assess Payments to Providers (Aug. 8, 1991, GAO/HRD-91-113).

Medicaid Expansions: Coverage Improves but State Fiscal Problems Jeopardize Continued Progress (June 25, 1991, GAO/HRD-91-78).

Substance Abuse Treatment: Medicaid Allows Some Services but Generally Limits Coverage (June 13, 1991, GAO/HRD-91-92).

Medicare: Further Changes Needed to Reduce Program Costs (June 13, 1991, GAO/T-HRD-91-34). Report on same topic (May 15, 1991, GAO/HRD-91-67).

Medicare: Payments for Clinical Laboratory Test Services Are Too High (June 10, 1991, GAO/HRD-91-59).

Medicare: Flawed Data Add Millions to Teaching Hospital Payments (June 4, 1991, GAO/IMTEC-91-31).

Medicaid: Alternatives for Improving the Distribution of Funds (May 20, 1991, GAO/HRD-91-66FS). Testimony on same topic (Dec. 7, 1990, GAO/T-HRD-91-5).

Medicare: Variations in Payments to Anesthesiologists Linked to Anesthesia Time (Apr. 30, 1991, GAO/HRD-91-43).

Medicare: HCFA Should Improve Internal Controls Over Part B Advance Payments (Apr. 17, 1991, GAO/HRD-91-81).

Medicaid: HCFA Needs Authority to Enforce Third-Party Requirements on States (Apr. 11, 1991, GAO/HRD-91-60).

Medicare: Millions in Disabled Beneficiary Expenditures Shifted to Employers (Apr. 10, 1991, GAO/HRD-91-24).

Medicare Claims Processing: HCFA Can Reduce the Disruptions Caused by Replacing Contractors (Apr. 4, 1991, GAO/HRD-91-44).

Medicare: Need for Consistent National Payment Policy for Special Anesthesia Services (Mar. 13, 1991, GAO/HRD-91-23).

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (Mar. 13, 1991, GAO/T-HRD-91-12). Report on same topic (Mar. 12, 1991, GAO/HRD-91-48).

Medicare: Millions in Potential Recoveries Not Being Sought By Contractors (Feb. 26, 1991, GAO/T-HRD-91-8).

Prenatal Care: Early Success in Enrolling Women Made Eligible by Medicaid Expansions (Feb. 11, 1991, GAO/PEMD-91-10).

Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (Jan. 25, 1991, GAO/HRD-91-32).

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